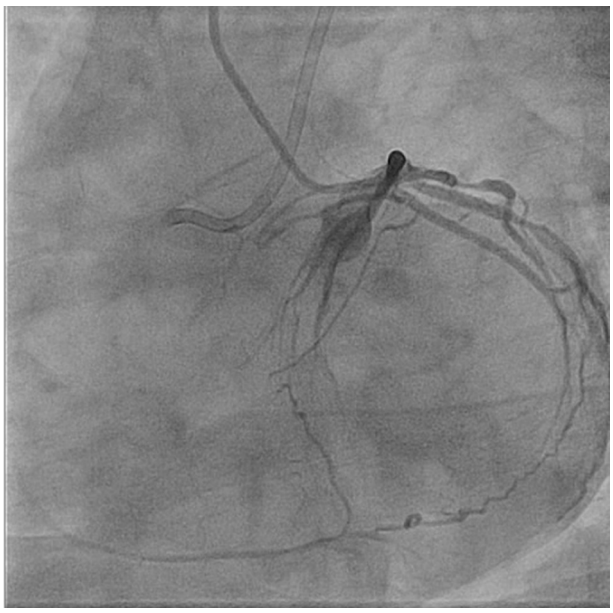


Case Summary.

- No flow/ Slow flow should always be kept in mind while tackling CTO other than PCI in ACS.
- Flow limiting dissection, coronary spasm and large thrombus should be ruled out before relabelling patient as true No flow/ Slow flow.
- If it persists, pharmacological agents should be used to tackle it.

TCTAP C-086

RCA CTO PCI: Case of Difficult Wiring Tackled with New Wires

P.L.N. Kapardhi[1]
[1]Apollo Hospitals, India

[CLINICAL INFORMATION]

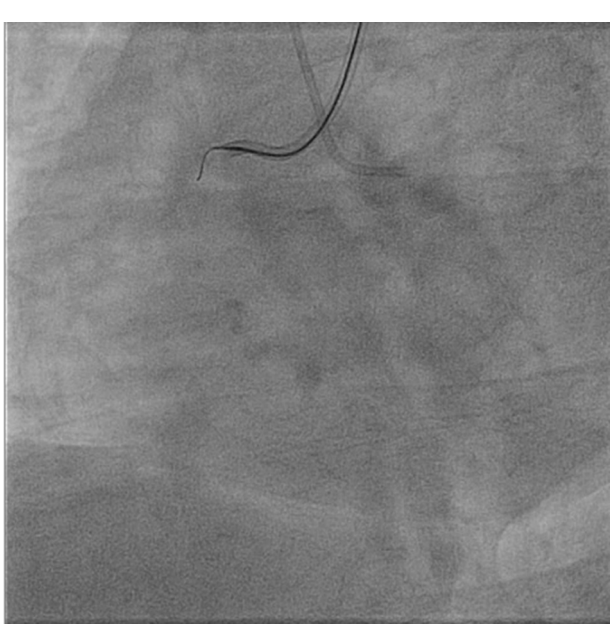
Patient initials or identifier number. BP

Relevant clinical history and physical exam. 42 Yrs Gentleman, presented with chest pain suggestive of exertional angina for last 6 months with increasing severity(crescendo Angina), Class III,having risk factor of Dyslipedem
Smoking and Diabetes

Relevant test results prior to catheterization. NORWMA Good LV Function
TMT +ve for inductive ischemia

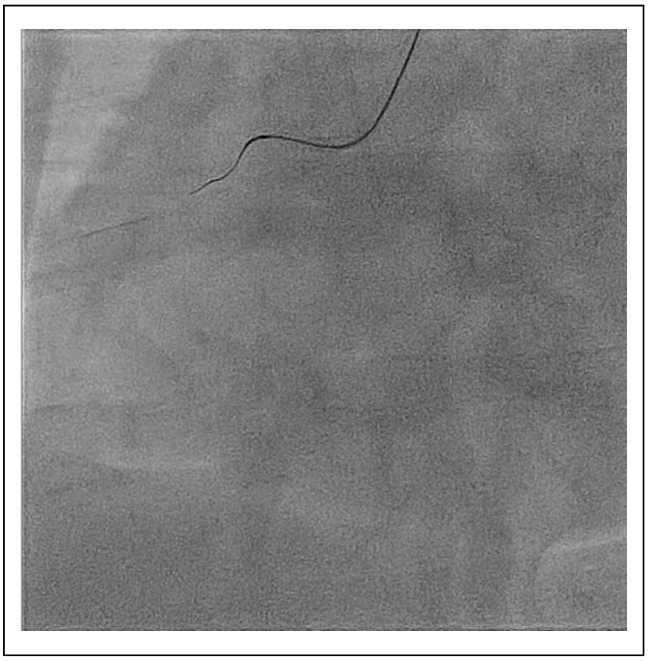
Relevant catheterization findings.

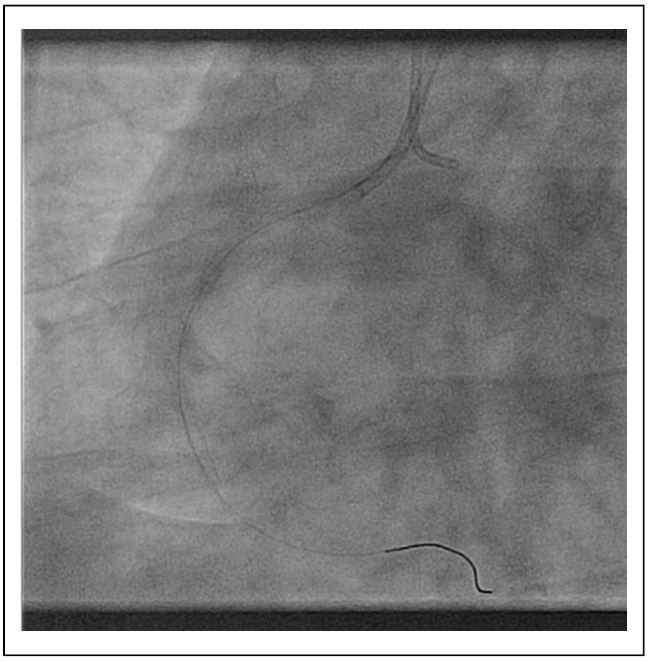
1. RCA Long segment CTO
2. LAD normal
3. LCX Non dominant, normal giving collaterals to RCA

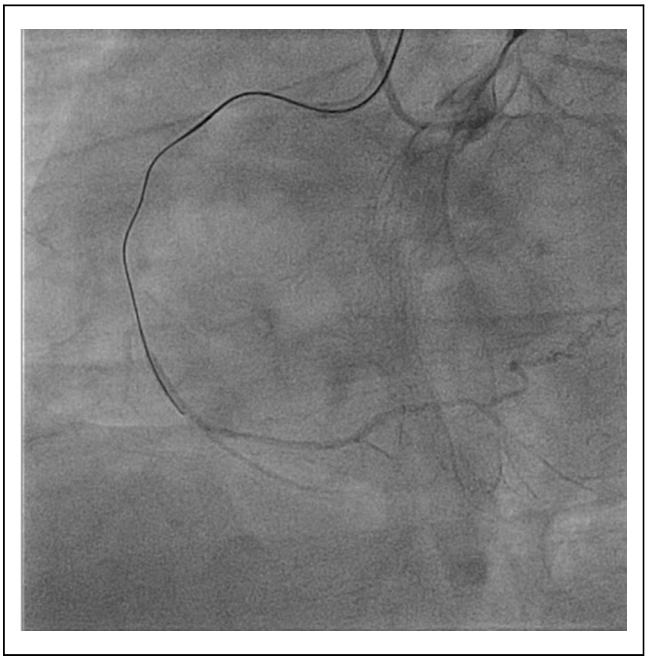


[INTERVENTIONAL MANAGEMENT]

Procedural step. Via Right Trans femoral route 7f FR guiding catheter was engaged to RCA and Via Right transradial approach LCA was engaged with TIGER catheter for contrallateral injections. Initially with corsair support, Fielder XTA wire was tried but,stuck in sub-initima,then wire was changed to GIAI I which was negotiated via long CTO Segment checking in RAO and LAO views successfully passed into distal true lumen. Subsequently predilated and deployed 2.5×38 DES distally and overlapped with 2.75×18 DES proximally. Post dilatation done with good result.







Case Summary.

- New Guide wires i.e. GAIA Series made the ante grade approach for long segment CTO interventions easier.
- In the present case, The hydrophilic wire Fielder Xta tracked subintimaly, without disturbing vessel anatomy. GAIA wire was chosen to minimize the PCI time.
- GAIA wire tracked the CTO segment in true planes guided by LAO and RAO diagonal planes successfully to enter the distal true lumen.
- Subsequent steps of Predilatation and stenting was done successfully. Usage of GAIA wire should be kept at low threshold while approaching CTO antegradely

TCTAP C-229

Double Anterograde Approach Percutaneous Coronary Intervention for Left Main Ostial Chronic Total Occlusion

Dong-Kie Kim,[1] Guang-Won Seo,[1] Pilsang Song,[1] Ki-Hun Kim,[2] Doo Il Kim[1]
[1]Inje University Haeundae Paik Hospital, Korea (Republic of); [2]Asan Medical Center, Korea (Republic of)

[CLINICAL INFORMATION]

Patient initials or identifier number. LSW

Relevant clinical history and physical exam. A 51 year-old male was presented with dyspnea on exertion for 4 months. He was a smoker and had hypertension with medication for 10 years. His clinical presentation was unstable angina. Physical examinations were unremarkable.

Relevant test results prior to catheterization. The initial electrocardiogram showed LV hypertrophy. The LV systolic function was normal on his echocardiography. The cardiac enzymes such as CK-MB and troponin-I were within normal range. Treadmill test was performed and it showed significant ST depression in precordial leads and blood pressure was dropped during the exercise.

Relevant catheterization findings. The coronary angiogram showed total occlusion at the proximal left main trunk. We could see the collateral flows via septal perforators from the RCA to the mLAD.